Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Texas Health of HEB

Respondent Name
City of Fort Worth

MFDR Tracking Number
M4-14-3532-01

Carrier's Austin Representative
Box Number 04

MFDR Date Received
August 1, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We submitted documentation to the carrier showing that our code used is applicable to the procedure preformed and we cannot change codes to fit their needs but they have denied our appeal."

Amount in Dispute: $4,110.22

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "…denied billing as submitted due to unsupported level of service."

Response Submitted by: CorVel Corporation

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 2, 2013	29880	$4,110.22	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403 sets out the reimbursement guidelines for outpatient facility services provided in an acute care hospital.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 125 – Denial/Reduction missing or inconsistent w/procedure
   - 128 – Please re-submit with appropriate CPT-4 Code
   - B12 – Svcs not documented in patient record

Issues

1. Did the requestor support that services were payable as submitted on medical bill?
2. Is the requestor entitled to reimbursement?

Findings

1. The carrier denied the disputed service as B12 – "Svcs not documented in patient record." 28 Texas Labor Code §134.403(d) states in pertinent part, "For coding, billing, reporting, and reimbursement of health care covered in this section, Texas workers' compensation system participants shall apply Medicare payment policies in effect on the date a service is provided with any additions or exceptions specified in this section…" Review of the Operative Report, Page 5, second paragraph states, "There were no tears or instabilities of the medial meniscus found." The third paragraph states, "There was an acute radial tear of the midportion of the lateral meniscus found."

   The narrative description of CPT Code 29880 is "Arthroscopy, knee, surgical; with meniscectomy (medial AND lateral), including any meniscal shaving) including debridement/shaving of articular cartilage (chondroplasty), same or separate compartment(s), when performed." The submitted documentation supports ONLY a tear in the lateral meniscus not the medial meniscus as described by this code. The carrier's denial is supported.
2. The requirements of 28 Texas Labor Code §134.403(d) are not met. No additional payment can be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	October , 2014 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.